State Children's Health Insurance Program (S-CHIP)

Implementation Guide

A Summary of the Objectives and Provisions of the "KidCare" Legislation Included in the Balanced Budget Act of 1997

First in a Series: November, 1997

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House Committee on Commerce

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Chairman's Note:

This booklet is intended to assist State implementation of the State Children's Health Insurance Program by answering many of the questions that have been raised to the Committee by State officials. It will be updated as needed to address further questions or to clarify any differences between the legislative language and intent and the program's federal implementation.

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Executive Summary

In June 1996, the U.S. General Accounting Office (GAO) issued its report on "Health Insurance for Children" -- and helped to spark a national debate on how to decrease the rate of uninsurance among low-income children in America. In its report, GAO published an alarming finding: “In 1994, an estimated 3.5 million children -- fully 35 percent of all uninsured children -- were eligible for Medicaid coverage that they did not receive.”

In short, despite unprecedented levels of Medicaid spending and Federal control, many Medicaid-eligible children do not receive the services to which they are entitled.

Over the last 30 years, the Medicaid program has experienced unprecedented growth in both its cost and the complexity of its Federal mandates and regulations. Although this evolution has been defended by some as making the Medicaid program more responsive to the needs of low-income Americans, the GAO report suggests that a different approach may be necessary to ensuring that the nation's low-income children do not lack the health coverage and services they need. In fact, the persistent problem of child uninsurance indicates that, despite its provision of substantial Federal funding and its passage of numerous operations mandates, Congress has yet to give the States the tools they need to ensure that millions of low-income uninsured children receive the assistance they currently lack.

Washington's failure to give States the tools needed to expand coverage and services to at-risk children has had a serious impact on the nation's health, its health care marketplace, and -- most important of all -- on the children themselves. Uninsured children, including those eligible for Medicaid coverage they do not now receive, are less likely to receive the primary and preventive care that can best improve their lifelong health.

Without such care, these children are more likely to be served by the so-called "sick-care" system, as opposed to the health care system. As a result, many of them may receive care only when they have already become ill, rather than in time to prevent many common ailments. In addition, these children may need more costly corrective treatment to address ailments that could have been prevented with coverage providing for consistent primary care.

The need for an effective and broad-based strategy is timely not solely because of the pressing needs of low-income uninsured children but because of the tremendous gains made independently by the States. For example, States have made significant progress in expanding children's coverage under Medicaid despite restrictive Federal regulations. In fact, GAO estimates that over a third of all Medicaid-covered children were made eligible by voluntary State expansions.

In an effort to further address the lack of coverage and services among low-income children, many States have also undertaken a variety of initiatives aimed at providing coverage and services to children. Principal among these efforts are State partnerships with nonprofit organizations and private entities to develop innovative health programs that have expanded access to responsive and effective health care for targeted youths. Unlike traditional Medicaid coverage, these initiatives have focused on the provision of insurance coverage and services that are tailored to meet the specific needs of the children targeted.

To build on these successes, the U.S. Congress created and the President signed the State Children's Health Insurance Program (S-CHIP), as part of the Balanced Budget Act of 1997. In recognition of the ongoing initiatives that States have developed to meet children's health care needs, S-CHIP provides States the resources, flexibility, and tools they need to expand the provision of coverage and services to uninsured low-income children.

Established under a new Title XXI of the Social Security Act, S-CHIP provides federal matching funds, beginning in 1998, to States to enable them to implement plans to initiate and expand the provision of child health care assistance to targeted uninsured, low-income children. The Balanced Budget Act of 1997 authorizes and appropriates specific sums for each of fiscal years 1998 through 2007 for S-CHIP and creates an entitlement to States for amounts in accordance with the provisions of the title.

Title XXI provides these resources to the States for the purpose of expanding access to quality primary and preventive care for targeted low-income children. To achieve this objective, the States and territories are permitted (1) to obtain health coverage and services in any manner that meets the requirements of the program, (2) to provide benefits under the States' Medicaid programs, or (3) through a combination of the two approaches.

In making this choice, States will consider a number of issues relating to the provisions of the State Children's Health Insurance Program. An explanation of many of the factors that will likely be central to this decision-making process is provided in the following chapters. Preceding that analysis, however, is a discussion of the approach States may choose in implementing S-CHIP.

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S-CHIP: How Best to Implement?

As detailed on the following pages, the State Children's Health Insurance Program gives States and territories the flexibility they need to best serve low-income uninsured children through coverage and services strategies that reflect their unique conditions and capabilities. The objective behind this approach is to create an opportunity for the States to establish child health programs that are free of the Medicaid program's many constraints to innovative and truly effective, efficient, and responsive health care initiatives.

That is the reason that Medicaid coverage is an option -- but not the sole option -- available to States.

Facing this choice, States are weighing the relative advantages and disadvantages of using S-CHIP to create or expand State-only programs versus using S-CHIP resources to finance an expansion of Medicaid. In order to aid in this process, the following analysis examines budgetary, benefits, and eligibility issues that are central to this decision-making process.

Fundamental to this analysis is a critical question: which approach -- a State-only program or a Medicaid expansion -- will best enable a State to expand coverage and services to the largest number of low-income uninsured children? After all, it was for the purpose of providing coverage and services to such children that the State Children's Health Insurance Program was created.

Which Approach is Better from a State's Budgetary Perspective?

From a budgetary perspective, a State-only S-CHIP program would enable States to expand coverage to more low-income uninsured children than would a Medicaid expansion. The factors supporting this conclusion include the following:

- The S-CHIP program's option to expand Medicaid is a relatively costly one for States to exercise. Although States that choose to use S-CHIP funds to enroll eligible children in Medicaid benefit from a lower match rate, the full cost of the federal match is taken from the State's Title XXI allotment. For example, in the case of State X (a State with a 50% Medicaid FMAP), the match rate would fall from 50% Federal-50% State to 65% Federal-35% State. However, where the Federal share of typical Medicaid costs is borne solely by the Federal government, the 65% Federal share of Medicaid costs incurred by S-CHIP children enrolled in the Medicaid program would come from State X's annual S-CHIP allotment. In short, the State would shoulder the full cost of Medicaid coverage for S-CHIP children -- and the number of children that could be served by its S-CHIP allotment would be reduced accordingly.

- The financing situation pertaining to the use of S-CHIP funds for private coverage appears identical to the above but actually differs in a very important respect. Any S-CHIP funds used by State X to buy private coverage for children would similarly involve a financing split of 65% Federal-35% State, with the former coming from State X's S-CHIP allotment. The key distinction, however, is that -- absent this program -- *all* costs of such coverage would be borne by State X. As a result, S-CHIP offers an opportunity for the State to extend private coverage to roughly three children using the same number of dollars that, before S-CHIP, were required to cover just one child. Put another way, S-CHIP reduces the cost of private coverage by two-thirds.

- The above distinction indicates that the choice made by a State in implementing S-CHIP will have significant budgetary consequences. If State X were to choose to use its S-CHIP funds to finance a Medicaid expansion, it would therefore reduce its ability to serve as many eligible children as would otherwise be possible. As noted above, this is because *more than three-quarters* of the funds being drawn from State X's S-CHIP allotment would be used to cover Medicaid costs that had previously been the sole responsibility of the Federal government (50% is nearly 77% of 65%).

- Put another way, the marginal budgetary benefit that State X would derive from S-CHIP will differ dramatically, depending upon the implementation approach it chooses. Assuming that the cost of covering an S-CHIP eligible child is $1,000:

  - If State X chooses to expand Medicaid, its per-child marginal benefit will be $150 (since its State-only costs would drop from $500 to $350).

  - If, however, State X chooses to use S-CHIP to create or expand a State-only program, its per-child marginal benefit will be $650 (since its pre-S-CHIP State-only costs of $1,000 would drop to $350).

  As a result, a State-only S-CHIP program would enable States to expand coverage to more low-income uninsured children than would an S-CHIP-financed Medicaid expansion.

Which Approach is Better from a Cost-of-Benefits Perspective?

From a benefits perspective, a State-only S-CHIP program would enable States to expand coverage to more low-income uninsured children than would an S-CHIP-financed Medicaid expansion. The factors supporting this conclusion include the following:

- The selection of Medicaid as the source of coverage for S-CHIP-eligible children significantly limits the flexibility States would otherwise enjoy. This is evident in a number of respects, but perhaps none are as central to the goal of maximizing the coverage of low-income uninsured children than flexibility in establishing a benefits package. As you know, Medicaid law requires that States provide beneficiaries a generous defined set of benefits, among which must be Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

- The concern raised by these Medicaid requirements is that they will increase the average per capita cost of coverage, thereby decreasing the number of low-income uninsured children a State can serve using its S-CHIP allotment. During the course of the last three years, the House Committee on Commerce conducted an in-depth review of the Medicaid program in order to find explanations for its spending growth and limited success in covering eligible children. What we found is critical to State implementation of S-CHIP: the Medicaid program's benefits mandates helped to fuel the inflation in program spending while limiting States' ability to extend coverage to all the needy children eligible for assistance.

- Just as important, the Medicaid program's mandated benefits package is often much more expensive than those provided by commercial plans. As the Kaiser Commission on the Future of Medicaid recently reported, Medicaid benefits "coverage levels exceed usual benefits offered by most commercial insurance

plans." Since S-CHIP's benefits provisions permit States to model their benefits package on existing commercial or State employee plans, it is widely anticipated that State benefits costs under S-CHIP will be at least 10% lower than they would be under a Medicaid expansion.

- The lesson for States as they prepare to implement S-CHIP seems clear: making the most of the new program's flexibility will enable States to maximize their coverage of uninsured low-income children. With respect to benefits, this can best be achieved only by focusing implementation on the establishment or expansion of State-only programs.

Which Approach is Better from a Program Eligibility Perspective?

From an eligibility perspective, a State-only S-CHIP program would enable States to expand coverage to more low-income uninsured children than would an S-CHIP-financed Medicaid expansion. The factors supporting this conclusion include the following:

- A State's choice between a State-only program and expansion of Medicaid will have a great impact on the State's ability to direct assistance where it is most needed. Under the Medicaid program, individuals are deemed eligible for assistance if they are members of a defined group (typically defined by income level). As a result, expanding to 150% of poverty would make all children with incomes under that level eligible for Medicaid coverage. By contrast, S-CHIP permits States to define the specific population to be served by the program. For example, a State could target S-CHIP assistance to a specific age group or a group residing in a specific locale, among other possible variants.

- This flexibility was built into the S-CHIP program in order to ensure that States would be able to invest their health care dollars where they would address the most pressing needs.

- With respect to the many States transitioning welfare recipients to work, the ability to target assistance where it is most needed is an important advantage over the Medicaid program. To illustrate just one example, a State could use S-CHIP resources in its efforts to help families successfully complete the transition from welfare to work. While no S-CHIP dollars may be used for individuals other than eligible children (without a waiver), the State could invest program funds to subsidize the cost of dependent care coverage for the eligible children of former welfare recipients after their year of transitional benefits has passed. Such a policy could achieve the twin goals of enabling families to stay off welfare by creating incentives for employers to hire and retain them while relieving new entrants to the workforce of the financial and emotional strain of making sure their children receive the coverage they need. The Medicaid program would offer a State none of the targeted flexibility that could be used to achieve these important objectives.

Which Approach Can Best Complement Existing Medicaid Coverage?

As detailed in this booklet, S-CHIP provides States a range of implementation options, covering the spectrum from a Medicaid expansion to a State-only coverage initiative to vouchers and tax credits provided for the purchase of qualified coverage. For virtually every State, however, the S-CHIP options chosen will reflect the status of their existing Medicaid program and Medicaid-based initiatives. Rather than serve as an impediment to more innovative approaches, however, such a situation can actually enable States to phase in non-Medicaid strategies by giving them the time to develop the infrastructure needed for such approaches.

An example of how a State can simultaneously pursue short- and long-term strategies for S-CHIP implementation follows:

Fiscal Year 1998:

- Submit State plan to the Secretary of Health and Human Services by late Spring to ensure approval and allotment of funds for FY 1998.
- Establish an S-CHIP coverage program that parallels an existing Medicaid managed care initiative for the purpose of extending private coverage to non-Medicaid-eligible children who reside in the same communities as those served by the Medicaid managed care program. Utilize the latter's existing administrative infrastructure, providers, and rates.
- Develop regional contracts for the extension of private coverage to other S-CHIP eligible children in other regions of the State.
- Roll-over remaining funds for use in Fiscal Years 1999 and 2000.

Fiscal Year 1999:

- Continue Medicaid-parallel operations in the selected region(s) of the State.
- Develop strategies for targeted assistance through such means as a State-only coverage program and dependent care coverage purchases using direct payment, vouchers, or refundable State income tax credits.
- Roll-over remaining funds, as available, for use in subsequent fiscal years.

Future Fiscal Years:

- Maintain Medicaid-parallel operations in the selected region(s) of the State, as needed.
- Implement targeted assistance initiatives utilizing such strategies as developed during FY 1999.

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S-CHIP: Eligibility Provisions

Children targeted by the State Children's Health Insurance Program must meet the eligibility standards as determined by the State in which they reside, be members of families with income below 200% of the Federal poverty level (or, in States with Medicaid applicable income levels at or above 200% of poverty, below the Medicaid applicable income level increased by no more than 50 percentage points), and not be eligible for Medicaid or covered under a group health plan or other health insurance.

Children who are inmates of a public institution, patients in institutions for mental disease, or eligible for health benefits under a State plan on the basis of a family member's employment with the State are not considered to be eligible. Targeted low-income children may include children covered under a health insurance program offered by a state which has been in operation since before July 2, 1997, and which receives no Federal funds.

Eligibility standards utilized by a State may include geography, age, income and resources (including standards for spending down income and disposition of resources), residency, disability status, access to other health insurance and duration of eligibility. However, the eligibility standards may not, within any defined class or group of covered targeted low-income children, cover children with higher family incomes before covering children with lower family incomes. They also may not deny eligibility to a child based on a preexisting medical condition.

Answers to Frequently-Asked Questions

Q. What legal entitlement does S-CHIP create?

A. Title XXI establishes an entitlement to S-CHIP funds for the States, the District of Columbia, and the territories. It does not create a legal entitlement to assistance for any individual under a state child health plan.

Q. As a condition of eligibility for S-CHIP funds, is a State required to enroll all Medicaid-eligible uninsured children and/or enroll all uninsured children eligible for assistance under Title XXI?

A. Although Congress encourages States to expand enrollment under both the Medicaid and S-CHIP programs to the greatest extent practicable, there is no requirement (as a condition of eligibility or otherwise) that States enroll all Medicaid-eligible uninsured children or all S-CHIP eligible children, with the sole exception of the program requirement that States enroll in their Medicaid program all children identified through the S-CHIP screening process as being Medicaid-eligible.

Q. What type of screening are States required to conduct?

A. Title XXI requires States to conduct intake and follow-up screening to ensure that children targeted for S-CHIP assistance meet the eligibility requirements of the title. In addition, States are required to describe in their S-CHIP plan the procedures used to ensure that children who are found through this process to be Medicaid-eligible are enrolled in the Medicaid program. However, States are not required to include in the S-CHIP screening process any procedures that are more extensive than those required to ensure eligibility under Title XXI, such as the calculation of income disregards that is a component of Medicaid eligibility screening.

Q. Can a State target assistance among S-CHIP-eligible children?

A. Yes. S-CHIP gives States the flexibility to target assistance to any eligible children. In other words, a State may target assistance to a specific age group or a group residing in a specific locale or region, among other possible variants. Nothing in Title XXI requires States to provide assistance to all program-eligible children or to provide assistance in the same manner in every area of a State.

Q. How does a State calculate its S-CHIP income eligibility level?

A. States are permitted to expend S-CHIP funds on behalf of children who, in addition to other applicable requirements, are members of families with incomes that are below 200% of the Federal poverty level and are within 50 percentage points of the State's Medicaid applicable income level. If a State's Medicaid applicable income level is at or above 200% of poverty, it may expend S-CHIP funds on behalf of eligible children with family income below the Medicaid applicable income level plus 50 percentage points. For example, if a State wishes to provide coverage and services to eligible 10-year-olds and the State's Medicaid applicable income level for that age group was 100% of the Federal poverty level (FPL) as of June 1, 1997, the State may use S-CHIP funds on behalf of eligible 10-year-olds whose family income is between 100 and 150% FPL. If the State's Medicaid applicable income level for that age group was 200% of poverty as of June 1, 1997, the State may use S-CHIP funds on behalf of eligible 10-year-olds whose family income is between 200 and 250% FPL.

Q. Do any exceptions apply to the income eligibility provisions of Title XXI?

A. Yes. S-CHIP permits States to establish health services initiatives using funds made available for non-coverage purposes (the total of which may not exceed 10% of total funds per quarter). Health service initiatives may include efforts to address chronic health problems suffered by a specified group, examples of which include low immunization rates among rural residents, a lack of primary dental care among inner city

children, and high infant mortality or serious health complications suffered by children of substance abusing mothers. In order to enable States to provide assistance to such at-risk populations, Title XXI permits States to include in a health services initiative children who are members of the population targeted by the initiative but whose family income falls outside the S-CHIP income range.

Q. Can States coordinate S-CHIP eligibility with other programs?

A. Yes. Title XXI gives States sufficient flexibility in identifying recipients of S-CHIP assistance to permit States to achieve coordination between S-CHIP and other programs. For example, a State that is engaged in assisting families in the transition from welfare to work may provide S-CHIP assistance to the children of welfare recipients (in a specific location or statewide) that are participating in the State's workfare program.

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S-CHIP: Benefits Provisions

The State Children's Health Insurance Program defines four options for minimum benefits packages for states choosing to provide child health assistance coverage under Title XXI instead of under the Medicaid program. The options include (1) health benefits coverage that is equivalent to the benefits coverage provided in a benchmark benefit package; (2) coverage of benefits that includes specified basic services, has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages, and includes specified additional services for which coverage is provided by the selected benchmark benefit package with an actuarial value of at least 75 percent of the actuarial value of the additional services provided by the selected benchmark benefit package; (3) coverage of comprehensive benefits provided by an existing State-based child health program; or (4) any other health benefits plan that the Secretary determines, upon application by a State, provides appropriate coverage for the targeted population of low-income children.

The benchmark benefit package is defined as one of the following three plans: the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered under the Federal Employees Health Benefits Plan; a health benefits coverage plan that is offered and generally available to State employees in the State involved; and the health coverage plan that is offered by an HMO and that has the largest commercial non-Medicaid enrollment of any such plan offered in the State involved.

A State choosing to provide benefits in the manner described as option (2) above must provide for at least the benefits in the basic benefits categories plus at least 75% of the actuarial value of any coverage provided under the benchmark plan for each of the benefits in the additional service categories. The basic benefits categories include inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray services, and well-baby and well-child care, including age-appropriate immunizations. The additional services categories include prescription drugs, mental health services, vision services, and hearing services.

For purposes of demonstrating actuarial equivalency, States must submit an actuarial memorandum meeting the requirements established under the title.

State child health plans are not permitted to impose pre-existing condition exclusions except if coverage is provided under a group health plan; under such circumstances, pre-existing condition exclusions may be imposed but only if they are consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Answers to Frequently-Asked Questions

Q. Is a State limited to its existing State employee health plans when selecting a benchmark benefit package?

A. No. S-CHIP does not affect a State's ability to create new health benefits coverage plans for its employees, nor does it prohibit the State from using a new plan as a benchmark benefit package. The only limitation in this regard is Title XXI's requirement that any State employee coverage plan selected as an S-CHIP benchmark by the State must be offered and generally available to the State's employees.

Q. When selecting the HMO benchmark option, should the State look to the HMO plan with the largest enrollment or the HMO with the largest enrollment?

A. Under S-CHIP, a State may select as its benchmark benefit package a health coverage plan that is offered by an HMO and that has the largest commercial non-Medicaid enrollment of any such plan offered in the State involved. In other words, the enrollment criteria relates to the plan (i.e., policy), not the carrier (i.e., HMO) that offers it.

Q. What if the benchmark benefit package that a State wishes to select does not offer one or more of the four additional services?

A. If the benchmark benefit package does not include coverage for one or more of the specified additional services, the resulting S-CHIP plan need not provide coverage for that or those services. Title XXI requires States that adopt the approach described as option 2 above to, among other requirements, provide additional services "for which coverage is provided under the benchmark benefit package," with an actuarial value equal to at least 75 percent of the actuarial value of each additional service provided by the benchmark benefit package. Since 75 percent of zero equals zero, an S-CHIP plan need not provide coverage of one or more of the four additional services if the benchmark benefit package does not provide such coverage.

Q. Is use of existing comprehensive State-based coverage plans as a benchmark benefit package limited to New York, Florida, and Pennsylvania?

A. Title XXI defines the existing plans that may be used as a benchmark as those which, among other criteria, are offered in New York, Florida, and Pennsylvania. We believe that nothing in S-CHIP limits the use of such plans as a benchmark benefit package to just those three States.

Q. What restrictions are established in Title XXI relating to abortion?

A. The S-CHIP program establishes two distinct limitations relating to abortion. First, Title XXI codifies, for the first time ever, the Hyde Amendment prohibition that up to now has had to be passed annually through the appropriations process. Specifically, the S-CHIP statutory language prohibits the use of funds to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion except in cases of rape, incest, or if the abortion is necessary to save the life of the mother. It is important to note that the provisions in which this language appears apply to funds expended under this title and under the State S-CHIP plan. Both variants prohibit the use of Federal funds and any other funds with which Federal funds are commingled. As a result, a State would have to establish a completely separate program to pay for abortion or coverage of abortion, and that program would have to be funded solely by State-only, local-only, or private-only funds -- not any State, local, and/or private funds used in coordination with S-CHIP. The second restriction in Title XXI that relates to abortion excludes any coverage of abortion provided by a benchmark benefit package from being considered in the determination of equivalent coverage or in the calculation of actuarial equivalency.

Q. Do statewideness or comparability requirements apply to benefits provided under Title XXI?

A. No, neither statewideness or comparability applies.

Q. How are the amount, duration, and scope of benefits under Title XXI established?

A. States are granted the discretion to establish the amount, duration, and scope of S-CHIP benefits through the process of developing their benefits package and outlining their coverage strategy in their S-CHIP plans.

Q. What is meant by the coordination of S-CHIP and other benefits called for under Title XXI?

A. By requiring States to include in their State child health plan a description of the coordination achieved between S-CHIP and other public and private health programs, Congress intends for States to maximize the utility of all resources expended to expand children's access to the quality primary and preventive care they need. For example, States are likely, and encouraged, to coordinate S-CHIP with their Maternal and Child Health programs by such means as meeting Title XXI's immunization provision solely through the use of MCHB funds in order to eliminate overlapping expenditures and make more S-CHIP resources available for the purchase of coverage and services for low-income uninsured children.

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S-CHIP: Cost-Sharing Provisions

Under Title XXI, State child health plans are required to include descriptions of the amount, if any, of premiums, deductibles, coinsurance, and other cost sharing imposed. Cost sharing can only be imposed pursuant to a public schedule and may not be imposed for preventive services or benefits. Premiums, deductibles, coinsurance, and other cost-sharing can only be imposed in a manner that does not favor children in higher-income families over those in families with lower incomes.

For targeted low-income children in families with income below 150% of poverty, premiums may be imposed only insofar as they do not exceed those maximum monthly charges permitted under Medicaid. Other cost sharing for such children may not exceed nominal amounts, as determined consistent with Medicaid regulations and as indexed by the Secretary of Health and Human Services to take into account the health care inflation for the period since the date of such regulations.

For targeted low-income children in families with income above 150% of the poverty line, premiums, deductibles, cost sharing or similar charges may be imposed on a sliding scale related to income only insofar as the total annual cost sharing for all targeted low-income children in a family does not exceed 5% of such family's income.

Cost sharing rules for coverage provided under Title XXI do not impact Medicaid cost sharing rules for any targeted low-income children covered under the Medicaid program.

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S-CHIP: Allotments to the States

The Balanced Budget Act of 1997 authorizes a total allotment of $24 billion for the State Children's Health Insurance Program. After deductions for S-CHIP expenses incurred in the Medicaid program, Title XXI provides allotments of $4.275 billion for each of 1998 through 2001, $3.15 billion for each of 2002 through 2004, $4.05 billion for 2005 and 2006, and $5.0 billion for 2007.

Before distribution among the States and the District of Columbia, total amounts authorized for child health assistance are reduced by 0.25% for allotments for the commonwealths and territories. Funds are then allotted to the States and the District based on the product of the number of low-income uncovered children for the state for the fiscal year and the state cost factor. The number of low-income uncovered children in families would, for each of FY1998 through FY2000, be equal to the 3-year average of uninsured children in families with income below 200% of poverty as estimated using the three most recent supplements to the March Current Population Surveys of the Bureau of the Census. For FY2001, low-income uncovered children would be equal to 75% of the 3-year average of the number of low-income children in the state for the fiscal year with no health insurance coverage plus 25% of the number of low-income children in the state. For years thereafter, low-income uncovered children would be equal to 50% of the 3-year average of the number of low-income children in the state for the fiscal year with no health insurance

coverage plus 50% of the number of low-income children in the state. The state cost factor for a fiscal year would be equal to the sum of .85 multiplied by the ratio of the annual average wages per employee in the state for such year to the national average wages per employee for such year and .15. The annual average wage per employee for each year would be calculated using the wages of employees in the health services industry as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

The agreement includes a floor on allotments for the states and the District of Colombia of $2 million. In case a state's allotment would be required to be raised to the $2 million floor, all other states' allotments would be adjusted in a pro rata manner such that the total of all allotment does not exceed the total of allotment available under Title XXI. States would have 3 years to spend their allotments.

Under S-CHIP, the Federal matching percentage (the enhanced FMAP) would be equal to the states' Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. All child health assistance, including child health coverage for targeted low-income children provided under the Medicaid program, would be subject to the same Federal matching percentage. The enhanced FMAP could be no higher than 85%.

The Secretary would make quarterly payments to each state with an approved child health assistance plan in amounts up the enhanced FMAP of child health assistance spending after reducing such allotment for the costs to the state's Medicaid program of presumptive eligibility and of covering targeted low-income uninsured children under the Medicaid program. Payments for child heath assistance may be made for insurance coverage that meets the requirements of S-CHIP, other initiatives for improving

child health, outreach and administration of the plan, except that no more than 10% of the total program spending could be used for other initiatives, outreach and administration. The 10% limitation on payments for child health assistance that does not meet the coverage requirements may be waived if a state establishes to the satisfaction of the Secretary that 1) the coverage provided to targeted low-income children meets the benefits and cost sharing requirements of Title XXI, 2) the cost of such coverage is no more than it would otherwise be under such section, and 3) such coverage is provided through the use of a community-based health delivery system.

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S-CHIP: Maintenance of Effort and Use of Funds Provisions

A state may use Title XXI funds to purchase family coverage for families that include targeted low-income children if the state establishes to the satisfaction of the Secretary that the purchase of such coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved and would not substitute for other health insurance coverage.

States providing health insurance coverage under S-CHIP may not make payments on behalf of a child if the child would be eligible for Medicaid using the income and resource standards and methodologies in place in the state on June 1, 1997. States that choose to use state child health assistance funds for enhanced Medicaid matching payments for expanded Medicaid eligibility would also be prohibited from using income and resource standards and methodologies for children that are more restrictive than those used as of June 1, 1997.

S-CHIP funds may not be used to (a) cover children who would be eligible for Medicaid using the income and assets standards or methodologies as in effect on June 1, (b) pay for services that a private insurer would be obligated to cover but for a provision of its insurance contract that limits its obligation because the child is eligible for child health assistance, (c) pay for services

for which payment can reasonably be expected to be made under any other federally operated or financed health insurance program or the Indian Health Service (d) pay for abortions, except in the case of a pregnancy resulting from rape or incest, or unless the mother is in danger of death unless an abortion is performed.

Federal funds or program spending that is largely subsidized by Federal funds may not be claimed as the required nonfederal share of costs.

The Secretary may make payments to states on the basis of advance estimates of spending made by the state and other investigation that the Secretary may find necessary, and may adjust payments as necessary to account for overpayment.

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S-CHIP: State Plan Requirements

State participating in Title XXI would be required to submit a plan to the Secretary that specifies how the state intends to use the Federal funds to provide health assistance to needy children consistent with requirements of the S-CHIP program. A state child health plan would have to include a description of: (a) the current insurance status of children, including targeted low-income children; (b) current state efforts to provide or obtain creditable coverage for uncovered children; and (c) how the plan is designed to be coordinated with current state efforts to increase creditable coverage of children, (d) the child health assistance to be provided under the plan for targeted low income children, including the proposed methods of delivery and utilization control systems, (e) eligibility standards, and (f) outreach activities, (g) and methods used to assure quality and appropriateness of care.

Procedures established for eligibility would have to ensure that: (a) only targeted low-income children received the assistance, (b) children found through screening to be eligible for medical assistance under the state's Medicaid program were enrolled in Medicaid, (c) the new insurance did not substitute for coverage under group health plans, (d) the provision of child health assistance to targeted low-income children in the state who are Indians as defined in the Indian Health Care Improvement Act, and (e) there was coordination with other public and private programs providing creditable coverage for low-income children.

The state plan would have to describe the nature of the assistance to be provided including: cost-sharing, the health care delivery method (e.g., managed care, fee-for-service, direct provision of services, or vouchers), and utilization control systems. A state would not be permitted to pay benefits to an individual to the extent that such benefits were available to the individual under another public or private health care insurance program. Payments in the form of a voucher or cash would not be considered income for purposes of eligibility for, or benefits provided, under any means-tested federal or federally-assisted program.

A state plan for child health insurance would become effective beginning in a specified calendar quarter that is at least 60 days after the plan is submitted. A state may amend its state child health plan at any time with a plan amendment. Plan amendments must be approved for the purposes of this title and would take effect on dates as specified in the amendment. Amendments restricting or limiting eligibility or benefits could not take effect until there had been public notice of the change. The Secretary would be required to promptly review state plans and amendments to determine compliance with the requirements of this title. Unless the state were notified in writing within 90 days that a plan or amendment was disapproved and the reasons for disapproval or that additional information was needed, the plan or amendment would be deemed approved. In the case of a disapproval, the Secretary would provide a state with a reasonable opportunity for correction.

A state child health plan would be required to identify (a) specific strategic objectives aimed at increasing health coverage among low-income children, (b) performance goals for each strategic objective identified, and (c) performance measures that are objective and verifiable, so that when compared with the performance goals, indicate the state's performance under this title. Plans must include assurances that the state will collect data, maintain records, and furnish reports as required by the Secretary

as well as provide the required annual assessments and evaluations. The Secretary would be required to have access to any records or information for reviews or audits as deemed necessary.

Plans would be required to include a description of the process for obtaining ongoing public involvement in the design and implementation of the plan, and the plan's budget to be updated periodically including details on the sources of the nonfederal share of plan spending.

A state child health plan would be required to describe strategic objectives, performance goals, and performance measures for providing child health assistance to targeted low-income children. Strategic objectives must be specific and relate to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. One or more performance goals would be specified for each strategic objective. Performance measures must be objective and independently verifiable and must be compared against performance goals in order to determine the state's performance under this title. The state child health plan would be required to include an assurance that the state will collect data, maintain records, and furnish report to the Secretary as needed. The plan would be required to describe the state's plans for annual assessment, reports and evaluations as required and to assure that the Secretary would have access to information for the purposes of review or audit as necessary. The plan would include a description of the budget and the process for involving the public in the design and implementation and ensuring ongoing public involvement. The following sections of Title XI would apply to States' Child Health Assistance Insurance Programs as they do under Medicaid: Section 1101(a)(1) relating to the definition of a state, Section 1116 relating to administrative and judicial review, Section 1124 relating to disclosure of ownership and related information, Section 1126 relating to disclosure of information about certain convicted individuals, Section 1128B(d) relating to criminal penalties, and Section 1132 relating to periods within which claims must be filed. The

following provisions of Title XI and XIX would apply the CHAP as they apply to the Medicaid program. Section 1128A relating to criminal penalties for certain additional charges, Section 1128B(d) relating to criminal penalties, Section 1902(a)(4)(c) relating to conflict of interest standards, Paragraphs (2) and (16) of Section 1903(i) relating to limitations on payments, 1903(m)(5) relating to contracts with managed care entities, Section 1903(w) relating to limitations on provider taxes and donations, Section 1921 relating to state licensure, and Sections 1932(d) and 1932(e) as added by the Balanced Budget Act of 1997 relating to fraud and sanctions for managed care entities.

A state would be required to provide an annual report to the Secretary by January 1 following the end of each fiscal year assessing the operation of the plan and the progress made in reducing the number of uncovered low-income children during the prior fiscal year. States would also be required to provide an evaluation by March 31, 2000, assessing (a) the effectiveness of the state plan in increasing the number of children with health coverage, (b) the effectiveness of specific elements of the plan, such as characteristics of families and children assisted and quality of coverage provided, (c) the effectiveness of other public and private programs in the state in increasing health coverage for children, (d) state activities to coordinate the plan with other public and private programs providing health care coverage, (e) trends in the state affecting the provision of health care to children, (f) plans for improving the availability of health insurance and health care for children, and (g) recommendations for improving the program, among other matters the state and Secretary consider appropriate. By December 31, 2000, the Secretary would be required to submit to Congress a report based on the state evaluations and make the report available to the public. The Secretary would be required to submit to Congress a report based on the state evaluations by December 31, 2001.

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